Montana Trauma Facility Resource Criteria

MONTANA TRAUMA FACILITY DESIGNATION CRITERIA (2024)
Montana Department of Public Health and Human Services
EMS and Trauma Systems Section

Note: Occasional variances from these standards may occur.
These should be reviewed as part of the hospital's trauma performance improvement process.

The following table shows levels of trauma facility designation and their essential ("E") or desirable ("D") characteristics.

TRAUMA FACILITY CRITERIA	LEVELS				
	CTC	RTC	ATH	CTH	TRF
CTC = Comprehensive Trauma Center (Level 1 equivalent) RTC = Regional Trauma Center (Level 2 equivalent) ATH = Area Trauma Hospital (Level 3 equivalent) CTH = Community Trauma Hospital (Level 4 equivalent) TRF = Trauma Receiving Facility (Level 5 equivalent)					
INSTITUTIONAL & ADMINISTRATIVE COMMITMENT					
Facility					
Demonstrated continuous institutional commitment-/-resolution by the hospital Board of Directors and Medical Staff within the last three years to maintain the human and physical resources to optimize trauma patient care provided at the facility.	E	E	E	E	E
The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	E	E	E	~~D~~E	~~D~~E
Hospital administration must demonstrate support for the research program (i.e., research equipment, biostatistical support, salary support, etc.)	E				
PROGRAM ORGANIZATION & GOVERNANCE					
Trauma Service					
A clinical service recognized in the medical staff structure that has the responsibility for the oversight of the care of the trauma patient. Specific delineation or credentialing of privileges for the medical staff on the Trauma Service must occur.	E	E	E		
Must care for at least 1,200 trauma patients annually who meet National Trauma Data Standard (NTDS) inclusion criteria or 240 NTDS patients with an Injury Severity Score (ISS) greater than 15 per year.	E				
Trauma Program					
There is an identifiable trauma program that has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	E	E	E	E	E
Trauma Team					
A team of care providers to provide initial evaluation, resuscitation and treatment for all injured patients meeting trauma system triage criteria. The members of the team must be identified and have written roles and responsibilities.	E	E	E	E	E
The trauma team is organized and directed by a general surgeon with demonstrated competence in trauma care who assumes responsibility for coordination of overall care of the trauma patient.	E	E	E	D	

E = Essential Criteria (required) D = Desired Criteria (not required)

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The trauma team is organized and directed by a physician with demonstrated competency in trauma care and is responsible for the overall provision of care for the trauma patient from resuscitation through discharge.				E	
The trauma team is organized and directed by a physician, physician assistant, or nurse practitioner with demonstrated competency in trauma care and is responsible for the overall provision of care for the trauma patient from resuscitation through discharge.					E
There are clearly written criteria for trauma team activation that are continuously evaluated by the multidisciplinary trauma committee.	E	E	E	E	E
Criteria for tiered activations must be clearly defined. Highest level of activation must include: • Confirmed BP less than 90 mm Hg at any time in adults, and age-specific hypotension in children; • Gunshot wounds to the neck, chest, or abdomen • GCS less than 9 (with mechanism of trauma); • Receipt of transfer patients from another hospital who require ongoing blood transfusion; • Patients intubated in the field and directly transported to the trauma center; • Patients who have respiratory compromise or need an emergent airway; and • Receipt of transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint).	E	E	E		
The general surgeon is expected to be present in the ED upon patient arrival for all patients meeting hospital specific criteria for the highest level of trauma team activation, given sufficient advance notification or within 15 minutes of notification 80% of the time.	E	E			
Trauma response criteria for general surgeon activation will be specified. The general surgeon is expected to be present in the ED upon patient arrival for those meeting criteria, if given sufficient advance notice or within 30 minutes of notification 80% of the time			E		
The Community Trauma Facility must have a trauma team plan for when the general surgeon is available and a second schema for when the general surgeon is not available. When available to respond, the general surgeon is expected to be present in the ED upon patient arrival for those meeting criteria, if given sufficient advance notice or within 30 minutes of notification 80% of the time.				E	

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Trauma Medical Director					
Board-certified or board eligible surgeon, credentialed to provide trauma care, and participates on trauma call panel. Serve as the director of a single trauma program. Holds current ATLS certification. The trauma director has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.	E	E	E		
TMD is an ATLS instructor or course director.	E	E	D		
Physician board-certified or board eligible in surgery with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.			E		
Physician board-certified or board eligible in a recognized specialty; with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.				E	
Physician, nurse practitioner, or physician assistant with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.					E
The trauma medical director must accrue an average of 12 hours annually or provide evidence of 36 hours in 3 years of verifiable external trauma-related CME or and maintain successful completion of most recent edition of ATLS course.	E^2	E^2	E^2	E^2	E^2
The trauma medical director must provide evidence of 36 hours in 3 years of verifiable external trauma-related CME or maintain successful completion of most recent edition of ATLS course.				E^2	E^2
TMD must attend 60% of all multidisciplinary trauma committee meetings. This obligation cannot be delegated.	E	E	E	E	E

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TMD must hold active membership in at least one national trauma organization and have attended at least one meeting during the last 3 years. (Membership in an ACS State COT is not equivalent to membership in a national organization)	E				
TMD must hold active membership in at least one regional, state, or national trauma organization and have attended at least one meeting during the last 3 years.		E	E		
TMD must attend at least one state trauma meeting during the last 3 years (examples include Trauma Systems Conference, Rocky Mountain Rural Trauma Symposium, Rimrock Trauma Conference, Spring Fever Conference etc.)	E	E	E	E	E
Trauma Coordinator/Trauma Program Manager					
A 1.0 full-time dedicated Registered Nurse or Advanced Practice Clinician working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Assumes day-to-day responsibility for process and PI activities for any nursing and ancillary personnel involved in the care of trauma patients. Activities include completion of the on-line trauma coordinator course, clinical oversight, with periodic rounding on admitted trauma patients, provision of clinical trauma education and prevention, performance improvement, provision of feedback to referring facility trauma programs, supervision of the trauma registry, and development of policies. Must be involved in local, regional and the state trauma system activities. Reporting structure must include the TMD to ensure an opportunity to provide leadership and partnership for the benefit of the program.	E	E	E		
A Registered Nurse or Advanced Practice Clinician working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include completion of the on-line trauma coordinator course, clinical care and oversight, provision of clinical trauma education and prevention, performance improvement, provision of feedback to referring facility trauma programs, trauma registry, utilization of the MT Trauma Treatment Manual, and involvement in local, regional and state trauma system activities. There must be dedicated and adequate hours for this position.			E	E	
A Registered Nurse, Advanced Practice Clinician or alternately a qualified allied health personnel working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include completion of the on-line trauma coordinator course, clinical care and oversight, provision of clinical					E

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trauma education and injury prevention, performance improvement, trauma registry, utilization of the MT Trauma Treatment Manual, and involvement in local, regional, and state trauma system activities. There must be dedicated and adequate hours for this position.					
Must provide evidence of 36 hours of trauma related continuing education during the last 3 years.	E	E	E		
Must provide evidence of 24 hours of trauma related continuing education during the last 3 years.				E	E
Hold current membership in a national or regional trauma organization.	E	E	E		
Trauma Registrar/Registry					
Designated trauma registrar working in concert with the trauma coordinator, with responsibility for data abstraction, entry into the trauma registry and ability to produce a variety of reports routinely and upon request. At least 0.5 FTE dedicated to the trauma registry per 200-300 annual patient entries. (Entries are defined as all patients that meet NTDS and state-specific inclusion criteria). There must be sufficient dedicated hours for this position to complete a minimum of 80% of patient records the trauma registry for each trauma patient within 60 days of the patient discharge date.	E	E	E		
Identified trauma registrar or trauma coordinator with responsibility for data abstraction, entry into the trauma registry and ability to produce a variety of reports routinely and upon request. There must be sufficient dedicated hours for this position to complete a minimum of 80% of patient records the trauma registry for each trauma patient within 60 days of the patient discharge date.			E	E	E
All staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting or data validation for the registry must: (1) complete the most recent version of the AAAM's Abbreviated Injury Scale (AIS) course within 12 months of hire; and (2) participate in a trauma registry course and ICD-10 course or refresher course every 5 years.	E	E	E		
Trauma Registrar (at least one) must currently be a Certified Abbreviated Injury Scale Specialist (CAISS)	E	E	E		
The trauma registrar must attend, or have previously attended, within 12 months of hire a national trauma registry course.		E	E		
The trauma registrar/trauma coordinator must attend, or have previously attended, within 12 months of hire a trauma registry training with the State Trauma Coordinator.				E	E
Active and timely participation in the State Trauma Registry (cases should be current per ARM 37.104.3014, which is 60 days following close of the quarter).	E	E	E	E	E

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Trauma Registry data must be collected in compliance with the NTDS inclusion criteria and Montana Trauma Registry specific criteria.	E	E	E	E	E
Registry data must have been submitted to the TQP Data Center (if ACS verified) and Montana Trauma Registry in the most recent call for data.	E	E	E		
Registry data must have been submitted to the Montana Central Site in the most recent call for data.				E	E
Must have a written data quality plan that details a process for measuring, monitoring, identifying and correcting data quality issues and ensures data is fit for use. Requires at least a quarterly review of data quality.	E	E	E	D	D
Trauma Registrar must accrue at least 24 hours of trauma-related continuing education (CE) during the previous 3 years.	E	E	E	D	D
Trauma Committees					
Multidisciplinary Trauma Committee functions with a multidisciplinary committee which includes representation from all trauma related services to assess and correct global trauma program process issues. This committee is chaired by the TMD with the major focus on PI activities, policy development, communication among all team members, development of standards of care, education, outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. meets regularly, takes attendance, has minutes, and works to correct overall program deficiencies to optimize trauma patient care.	E	E	E	E	E
Multidisciplinary Trauma Peer Review functions with a multidisciplinary committee of medical disciplines requires attendance of medical staff active in trauma resuscitation, including the trauma coordinator, to review systemic issues and/or provider issues, as well as proposed improvements to the care and safety of the injured. Must meet regularly and document comprehensive minutes that capture the essence of the discussion and consensus of the participants and documenting loop closure. Must systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine opportunities for improvement. including the trauma coordinator involved in caring for trauma patients to perform confidential, protected peer review for issues such as response times, appropriateness and timeliness of care, and evaluation of care priorities. This committee under the auspices of performance improvement meets regularly takes attendance and	E	E	E	E	E

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~~documents performance improvement evaluation and agreed upon action plans.~~					
The trauma medical director ensures dissemination of information and findings from the trauma peer review meetings to the medical providers not attending the meeting.	E	E	E	E	E
Must adopt/utilize evidence-based clinical practice guidelines/protocols/algorithms that are reviewed at least every three years.	E	E	E	E	E
Trauma System Participation					
There is active involvement by the hospital trauma program staff in state/regional trauma system planning, development, and operation.	E	E	E	E	E
Participation in the statewide trauma system including participation in at least 50% of Regional Trauma Advisory Committees; support of regional and state performance improvement programs; and submission of data to the Montana State Trauma Registry.	E	E	E	E	E
Prehospital Trauma Care					
The trauma program reviews pre-hospital protocols and policies related to care of the injured patient. A physician/provider from the ED or trauma program must participate in the prehospital Performance Improvement (PI) process, including assisting EMS agency medical directors in the development and adoption of prehospital care protocols relevant to care of the trauma patient.	E	E	E	E	E
The trauma program reviews pre-hospital protocols and policies related to care of the injured specialty patient: Pediatrics, Geriatrics, Obstetrical	E	E	E	E	E
Trauma team activation criteria have been provided to EMS and are readily available to allow for appropriate and timely trauma team activation.	E	E	E	E	E
EMS has representation on the multidisciplinary trauma committee or documentation of involvement where perspective and issues are presented and addressed.	E	E	E	E	E
Review of prehospital trauma care is included in the trauma performance improvement program.	E	E	E	E	E
EMS is provided feedback through the trauma performance improvement program, which includes accuracy of triage and provision of care, outcomes of their patients and any potential opportunities for improvement in initial care.	E	E	E	E	E
Participates in the training of prehospital personnel.	E	E	E	D	D
PERSONNEL & SERVICE RESOURCES					
General / Trauma Surgeon					
Full, unrestricted general surgery privileges	E	E	E	E	
Board-certified or board eligible	E[1]	E[1]	E[1]	D[1]	
ATLS course completion	E	E	E	E	

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Must remain current in board-certification to satisfy CME requirements.	E	E	E	E	
Attendance of each of the general surgeons at a minimum of 50% of the trauma peer review committee meetings.	E	E	E	E	
Must have trauma surgery coverage by senior (PGY3, 4 or 5) general surgery residents and/or fellows from an accredited ACGME program.	E				
Published back-up schedule and dedicated to a single hospital when on call or performance improvement process in place to demonstrate prompt general surgeon availability.	E	E	D	D	
Must have a documented backup plan for trauma surgery which must include transferring patients requiring surgery to a higher level of care when trauma surgery is unavailable.			E	E	
Process in place to assure the on-call general surgeon is notified and responds to the ED within the required time frame for trauma patient resuscitation. The trauma performance improvement process will monitor each surgeon's notification and response times.	E	E	E	E	
Trauma surgeon must be present in the operating suite for the key portions of the surgical procedures for which they are responsible and must be immediately available throughout the entire procedure.	E	E	E	E	
Shared roles and responsibilities of trauma surgeons and emergency medicine physicians must be defined and approved by the TMD.	E	E	E		
Emergency Medicine					
Physicians are must be board-certified or board eligible in emergency medicine.	E[1]	E[1]			
Physicians must be board-certified or board eligible in emergency medicine or a specialty other than emergency medicine.			E[1]	E[1]	
Emergency Department physician medical director must be board-certified or board eligible.	E[1]	E[1]	E[1]	D[1]	D[1]
Emergency Department covered by medical providers qualified to care for patients with traumatic injuries who can initiate resuscitative measures.	E	E	E	E	E
A board-certified or board eligible emergency medicine physician must be present in the ED at all times.	E[1]	E[1]	D		
Emergency Department coverage may be physician, physician assistant, or nurse practitioner on-call and promptly available.				E	E
Must remain current with board certification to satisfy CME requirements. If functioning as an ED provider or providing care in the ED for patients outside of current board-certified specialty and/or are an Advanced Practice Practitioner, current ATLS is required.	E	E	E	E	E

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CALS (Comprehensive Advanced Life Support) Provider certification (WITH completion of CALS Trauma Module) may substitute for ATLS recertification for Community & Trauma Receiving Facilities. Provider must be current in or be pursuing the most recent ATLS edition before CALS may be substituted for recertification.				E	E
Emergency Department trauma liaison (may be Trauma Medical Director if ED Provider serves in that role).	E	E	E	E	E
Attendance of an emergency physician representative at a minimum of 50% of the trauma peer review committee meetings.	E[2]	E[2]	E[2]	E[2]	D
Attendance of all ED providers at a minimum of 50% of the trauma peer review committee meetings.					E[2]
Anesthesia – MD or CRNA					
Board certified or board eligible anesthesiologist trauma liaison.	E	E	D	D	
Anesthesia trauma liaison.	E	E	E	E	
CRNAs and certified anesthesiologist assistants who are licensed to practice independently can serve as anesthesia liaison.			E	E	
Attendance of anesthesia representative at a minimum of 50% of the trauma peer review committee meetings.	E	E	E	E	
The availability of Aanesthesia and the absence of delays in airway control and operative anesthesia management must be identified and reviewed to determine reasons for delay, adverse outcomes and opportunities for improvement.	E	E	E	E	
Anesthesia services must be available within 15 minutes of request, and attending anesthesiologist must be present within 30 minutes of request of all operations.	E	E			
Anesthesia services must be available within 30 minutes of request.			E	D	
Neurologic Surgery (if available…) **Neurosurgery** E*: Applies only to Area Trauma Hospitals with neurotrauma capabilities.					
Board-certified or board-eligible neurosurgeons continuously available for care of the neurotrauma patient.	E[1]	E[1]			
Board-certified or board-eligible neurosurgeons.			E[1]*/ D[1]		
ATLS course completion.	D	D	D		
Must remain current in board-certification to satisfy CME requirements.	E	E	E*/D		
Board-certified or board eligible Nneurosurgical trauma liaison.	E[1]	E[1]	E[1]*/ D[1]		
Attendance of a neurosurgery representative at a minimum of 50% multidisciplinary peer review committee meetings.	E[2]	E[2]	E[2]*/ D[2]		

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Neurosurgical evaluation must occur within 30 minutes for any patient with severe TBI (GCS <9), moderate TBI (GCS 9-12) with evidence of intracranial mass lesion, neurologic deficit from spinal cord injury, or at the discretion of the trauma surgeon.	E	E	E*/D		
Must have a written plan approved by the TMD that defines the types of neurotrauma injury that may be treated at the center.			E	D	
Must have a neurotrauma contingency plan for when neurosurgery capabilities are encumbered or overwhelmed.	E	E	E*/D		
Orthopaedic Surgery *E*: Applies only with orthopedic capabilities*					
Board certified or board eligible orthopedic surgeons continuously available for the care of trauma patients and must have a contingency plan for when orthopedic trauma capabilities become burdened or overwhelmed.	E[1]	E[1]	E[1]		
ATLS course completion.	D	D	D	D	
Must remain current in board-certification to satisfy CME requirements.	E	E	E	D	
Board-certified or board eligible oOrthopaedic trauma liaison.	E[1]	E[1]	E[1]	D[1]	
Orthopedic trauma liaison must have completed an orthopedic traumatology fellowship approved by the Orthopaedic Trauma Association.	E				
Attendance of an orthopaedic surgery representative at a minimum of 50% of the trauma peer review committee meetings.	E[2]	E[2]	E[2]	D[2]E*	
Orthopedic surgeon must be at bedside within 30 minutes of request for any patient that is hemodynamically unstable due to pelvic fracture, has suspected compartment syndrome, fractures/dislocations at risk for avascular necrosis or vascular compromise, or at the discretion of the trauma surgeon.	E	E	E		
Must have treatment guidelines in place for orthopedic injuries, including pelvic ring fractures, long bone fractures, open extremity fractures, and hip fractures in geriatric patients.	E	E	E	D	
Radiologist					
Board certified or board eligible.	E	E	E		
Board-certified or board eligible Rradiologist trauma liaison.	E	E	D E		
Attendance of a radiologist representative at a minimum of 50% of the trauma peer review committee meetings.	E[2]	E[2]	E[2]	D[2]	D[2]
A radiologist must have access to patient images and be available for imaging interpretation, in person or by phone, within 30 minutes of request.	E	E	E	D	D
Interventional Radiology					
Necessary human and physical resources continuously available to provide endovascular or interventional radiology procedure for hemorrhage control within 60 minutes of request and arterial puncture.	E	E	D		

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ICU *Critical Care Physician*					
Board-certified or board-eligible critical care ICU physician. trauma liaison	E	E	E		
Critical Care surgical director board-certified or board-eligible in surgical critical care and actively participates in Critical Care administration. May be the TMD.	E				
Critical Care surgical director board-certified or board-eligible in general surgery and actively participates in Critical Care administration. May be the TMD.		E	D		
At least one intensivist must be board-certified or board eligible in surgical critical care.		E			
ICU Critical Care/Hospitalist trauma liaison.				D	
Attendance of an ICU a critical care physician representative at a minimum of 50% of the trauma peer review committee meetings.	E	E	E	D	
Advanced Practitioners					
Advanced practitioners who participate in the initial evaluation of trauma patients must demonstrate currency as an ATLS provider.	E	E	E	E	E
Geriatric Provider					
A geriatric provider trauma liaison (may be a geriatrician, physician with expertise and a focus in geriatrics, or an advanced practice provider with certification and expertise in geriatrics).	E	E	D		
Additional Medical Specialists					
• Pain Management (with expertise to perform regional nerve blocks)	E	E	D		
• Physiatry	E	E	D		
• Psychiatry	E	E	D		
Institutionally defined, response parameters for consultants addressing time-critical injuries should be determined and monitored. Variances should be documented and reviewed regarding reason for delay, opportunities for improvement and corrective actions.	E	E	E	D	
*Must have continuous availability of the following surgical specialties:					
*Cardiothoracic surgery	E	E			
Craniofacial expertise	E	D			
Critical care medicine	E	E	D	D	
*Hand surgery	E	E	D		
Neurologic surgery		E	D		
Dedicated to one hospital or performance improvement process in place to demonstrate prompt neurosurgeon availability		E	D		
*Obstetric/Gynecologic surgery	E	E	D	D	
*Ophthalmic surgery	E	E	D		
Oral / maxillofacial surgery		E	D		
*Orthopaedic surgery		E	D	D	

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*Otolaryngology	E	E	D		
*Plastic surgery	E	E	D		
Pediatric service or Pediatrician availability	E	E	E		
Radiology	E	E	E	D	
*Replantation Services (if not continuously available must have a triage and transfer process with a replant center).	E	E	D		
Soft tissue coverage including microvascular for free flap coverage.	E	D			
Thoracic surgery		E	D		
*Urologic surgery	E	E	D		
*Vascular surgery	E	E	D		
*Must have continuous coverage of the following medical specialists:					
* Cardiology	E	E	E		
*Gastroenterology	E	E	E		
*Internal medicine or pediatrics	E	E	E		
*Infectious Disease	E	E	E		
*Nephrology	E	E	E		
*Pulmonary Medicine	E	E	E		
FACILITIES/RESOURCES/CAPABILITIES					
Emergency Department					
Designated physician director		E	E	D	D
Emergency Department coverage by in-house emergency physician		E	E		
Emergency Department coverage by in-house physician, physician assistant, or nurse practitioner				D	D
A board-certified or board-eligible emergency physician must be present in the emergency department at all times.	E[1]	E[1]			
If the in-house emergency medical provider must be temporarily out of the department to cover in-house emergencies, there must be a Performance Improvement (-PI) process in place to assure that care of the trauma patient is not adversely affected		E	E		

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There is a system in place to assure early notification of the on-call medical provider, so they can be present in the ED at the time of trauma patient arrival. This is tracked in the trauma performance improvement process.				E	E
Emergency Department staffing shall ensure nursing coverage for immediate care of the trauma patient.	E	E	E	E	E
Trauma nursing education: Maintenance of TNCC/ATCN or equivalent.	E	E	E	E	~~D~~E
Trauma nursing education: 6 hours of verifiable trauma-related education annually or trauma-related skill competency through internal or external educational process.	E	E	E	E	E
Nursing personnel to provide continual monitoring of the trauma patient from hospital arrival to disposition to ICU, OR, floor or transfer to another facility.	E	E	E	E	E
Equipment for resuscitation for patients of **ALL AGES**					
Airway control and ventilation equipment including laryngoscope and endotracheal tubes, bag-mask resuscitator and oxygen source	E	E	E	E	E
Rescue airway devices	E	E	E	E	E
Pulse oximetry	E	E	E	E	E
Suction devices	E	E	E	E	E
End-tidal CO_2 detector	E	E	E	E	E
Cardiac monitor and defibrillator	E	E	E	E	E
Internal paddles	E	E	E		
Waveform capnography	E	E	E	E	E
Standard IV fluids and administration sets	E	E	E	E	E
Large bore intravenous catheters	E	E	E	E	E
Sterile surgical sets for:					
Airway control/cricothyrotomy	E	E	E	E	E
Thoracostomy (chest tube insertion)	E	E	E	E	E
Central line insertion	E	E	E	D	D
Thoracotomy	E	E	E		
Peritoneal lavage or ability to do FAST ultrasound exams	E	E	E	E	D
Arterial pressure monitoring	E	E	E	D	
Ultrasound availability	E	E	E	D	D
Drugs necessary for emergency care	E	E	E	E	E
Cervical stabilization collars	E	E	E	E	E
Pelvic stabilization method	E	E	E	E	E
Pediatric equipment appropriately organized.	E	E	E	E	E
Current pediatric length-based resuscitation tape	E	E	E	E	E
Intraosseous Insertion Device	E	E	E	E	E

Thermal control equipment:
   Blood and fluids
   Patient
	
	E
	E
		
		E
		E
			
			E
			E
				
				E
				E
					
					E
					E

E = Essential Criteria (required) D = Desired Criteria (not required)

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Montana Trauma Facility Resource Criteria

TRAUMA FACILITY CRITERIA	LEVELS				
	CTC	RTC	ATH	CTH	TRF
CTC = Comprehensive Trauma Center (Level 1 equivalent) RTC = Regional Trauma Center (Level 2 equivalent) ATH = Area Trauma Hospital (Level 3 equivalent) CTH = Community Trauma Hospital (Level 4 equivalent) TRF = Trauma Receiving Facility (Level 5 equivalent)					
Resuscitation room	E	E	E	E	E
Rapid fluid infuser system	E	E	E	E	E
Communication with EMS vehicles	E	E	E	E	E
Operating Room (OR)					
Adequately staffed and available in a timely fashion 24 hours-/-day.	E	E	E	D	
OR booking policy that defines target for timeliness to the OR based on level of urgency and trauma priorities.	E	E	E		
OR must be adequately staffed and available within 15 minutes. If the first OR is occupied, an additional OR must be staffed and available.	E	E			
OR must be adequately staffed and available within 30 minutes. Access to the OR must be made available for nonemergent orthopedic trauma.			E		
Dedicated OR for fracture care of non-emergent orthopedic trauma.	E	E			
Anesthesia services must be available in-house 24 hours/day.	E	E			
Trauma performance improvement will monitor OR operating room availability and on-call surgical staff response times. must be routinely monitored and Any case which exceeds the institutionally agreed upon response time must be reviewed to identify for reasons for the delay and opportunities for improvement.	E	E	E	D	
Trauma-specific training opportunities, applicable to the specialty, are available for all RNs working in the OR.	D	D	D	D	
Age-specific Equipment					
Equipment for monitoring and resuscitative	E	E	E	E	
Cardiopulmonary bypass	E	E			
Thermal control equipment: Blood and fluids Patient Operating room	E E E	E E E	E E E	E E E	
X-ray capability	E	E	E	E	
Endoscopes, bronchoscopes	E	E	E	D	
Craniotomy instruments	E	E	D	D	
Equipment for long bone and pelvic fixation	E	E	E	D	
Rapid fluid infuser system	E	E	E	E	
Post-Anesthetic Recovery Room (PACU) *(ICU is acceptable)*					
Registered nurses available 24 hours-/-day	E	E	E	D	
-Trauma-specific training opportunities, applicable to the specialty, are available for all RNs working in the PACU.	E	E	E	D	
Age-specific Equipment					
Equipment for monitoring and resuscitation	E	E	E	E	
Intracranial pressure monitoring equipment	E	E	D	D	
Pulse oximetry	E	E	E	E	
Thermal control equipment: Blood and fluids Patient	E E	E E	E E	E E	

E = Essential Criteria (required) D = Desired Criteria (not required)   14

Montana Trauma Facility Resource Criteria

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Intensive Care Unit *(if available…)*					
Director must be board certified in surgical critical care.	E				
Director or co-director must be surgeon, board certified in critical care.		E	D		
Designated Physician/APC director.			E	D	
Trauma surgeon remains in charge of the ~~multiple~~ multisystem trauma patient in the ICU.	E	E	E	E	
ICU ~~service in house 24 hours / day~~ physicians immediately available within 15 minutes of request.	E	E	D		
Provider coverage of the ICU must be available within 30 minutes of request, with a formal plan for emergency coverage.			E	D	
Nurse-to-patient ratio in the ICU must be 1:1 or 1:2 depending on patient acuity.	E	E	E	E	
Registered nurses with 6 hours trauma education annually.	E	E	E	E	
Trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service pursuant to hospital policy.	E	E	E	E	
Equipment for monitoring and resuscitation of trauma patient.	E	E	E		
Cerebral monitoring equipment.	E	E	~~D~~ E*/D		
Cardiopulmonary bypass equipment must be immediately available when required or a contingency plan must exist to provide emergency cardiac surgical care.	E	E			
Pulmonary artery monitoring equipment	E	E	E		
Thermal control equipment: Blood and fluids Patient	 E E	 E E	 E E	 E E	
Pediatric Services					
Adult centers that care for 100 or more injured children under age 15 years of age who meet trauma registry inclusion requirements must have the following: • Pediatric emergency department area • Pediatric intensive care area	 E E	 E E	 E E		
Appropriate resuscitation equipment to care for all ages of pediatric patients	E	E	E	E	E
Must have a process in place to assess children for non-accidental trauma	E	E	E	E	E
Emergency Department must evaluate their pediatric readiness and have a plan to address any deficiencies. Pediatric readiness refers to the infrastructure, administration and coordination of care, personnel, pediatric-specific policies and equipment to ensure the center is prepared to provide care to an injured child.	E	E	E	D	D
Respiratory Therapy Services					
In-house respiratory therapist continuously available (24/7/365)	E	E	E		
Respiratory therapist available				D	D

E = Essential Criteria (required) D = Desired Criteria (not required)   15

Montana Trauma Facility Resource Criteria

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Renal Replacement Therapy Services					
Renal replacement therapy available to support patients with acute renal therapy.	E	E			
Renal replacement therapy available to support patients with acute renal therapy or have a transfer agreement and process in place.			E		
Radiological Services					
A radiologist must be available within 30 minutes in person or by teleradiology for the interpretation of images.	E	E	E		
Radiologists, in person or by teleradiology, are promptly available for interpretation of radiographic studies.				E	E
Availability of the following services 24 hours/day within time frame specified: • Conventional radiography (15 minutes) • Computed Tomography (CT) (15 minutes) • Point of Care Ultrasound (15 minutes) • Interventional radiologic procedures (1 hour) • MRI (2 hours)	E	E			
Availability of the following services 24 hours/day within time frame specified: • Conventional radiology (30 minutes) • CT (30 minutes) • Point of Care Ultrasound (15 minutes)			E	D	D
In-house radiology technologist.	E	E	E		
Radiology technologist available in-house or on-call 24 hours/-day.				E	D
~~Radiologists are promptly available for interpretation of radiographs, CT scans, performance of complex imaging studies and interventional procedures.~~	~~E~~	~~E~~	~~E~~		
-Must have a mechanism to remotely view radiographic images from referring hospitals within their regional catchment area.	E	E			
Radiologist diagnostic information is communicated in a written form in a timely manner and includes evidence that critical findings were communicated to the trauma team.	E	E	E	E	E
Final radiology reports accurately reflect communications, including changes between preliminary and final interpretations.	E	E	E	E	E
Documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.	E	E	E	E	E
Angiography	E	E	~~D~~ E		
Ultrasound	E	E	E	D	D
Computed Tomography	E	E	E	E	D
In-house CT technologist	E	E	E		
CT technologist available in-house or on-call 24 hours/-day				E	D
CT has pediatric dose reduction protocols/policies	E	E	E	E	E
Magnetic Resonance Imaging	E	E	E	D	D

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Montana Trauma Facility Resource Criteria

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MRI technologist in-house or on-call 24 hours-/-day	E	E	E		
Must routinely monitor on-call radiology, CT and MRI technologist institutionally agreed upon response times and review for-reasons for any delay and opportunities for improvement.	E	E	E	E	E
Clinical Laboratory Service					
In-house laboratory technician	E	E	E		
Laboratory technician available in-house or on-call 24 hours-/-day				E	E
Must routinely monitor on-call technician institutionally agreed upon response time and review must be reviewed for reasons for any delay and opportunities for improvement.	E	E	E	E	E
Standard analysis of blood, urine, and other body fluids, including micro-sampling when appropriate	E	E	E	E	E
Blood typing and cross-matching	E	E	E	E	D
Coagulation Studies	E	E	E	E	D-E
Massive or Rapid Transfusion Policy (clinical and laboratory) if blood is available at the facility	E	E	E	E	E
-The blood bank has an adequate supply of packed red blood cells, plasma, platelets, and cryoprecipitate or coagulation factors to meet the needs of the injured patient.	E	E			
-The blood bank has an adequate supply of packed red blood cells and plasma to meet the needs of the injured patient.			E	D	D
Process of care for rapid reversal of anticoagulation	E	E	E	E	E
Blood gases and pH determinations	E	E	E	E	E
Microbiology	E	E	E	E	D
-Operating microscope available 24 hours/day	E	E			
Drug and alcohol screening	E	E	E	D	D
Rehabilitation Allied Health-Services					
-Nutrition Support	E	E	E	D	D
Physical Therapy (7 days/week)	E	E			
Physical Therapy			E	D	D
Occupational Therapy (7 days/week)	E	E			
Occupational Therapy			E	D	D
Social Services (7 days/week)	E	E			
Social Services			E	D	D
Speech Therapy	E	E	E	D	D
PERFORMANCE IMPROVEMENT					
There is a comprehensive, written performance improvement (PI) plan outlining the PI process, organizational structure, event identification, list of audit filters and defined levels of review. Needs to be reviewed annually.	E	E	E	E	E
-There is a clearly defined performance improvement program for the trauma patient population.	E	E	E	E	E

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Montana Trauma Facility Resource Criteria

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The Trauma PI program must be independent of the hospital or departmental PI program, but it must report to the hospital or departmental PI program.	E	E	E	D	D
Must have documented evidence of event identification, effective use of audit filters, demonstrated loop closure, and attempts at corrective actions and strategies for continued improvement over time.	E	E	E	E	E
There is a process to identify the trauma patient population for performance improvement review.	E	E	E	E	E
At least 0.5 FTE dedicated PI personnel (if annual volume exceeds 500 patient entries) and 1.0 FTE if volume >1000 patient entries that meet NTDB and State inclusion criteria	E	E	E		
There is a process where clinical care issues are discussed in confidential, protected trauma care peer review with analysis at regular intervals to meet the needs of the trauma program. Trauma Coordinators are to be present at trauma peer review.	E	E	E	E	E
There is a process where operational issues are discussed in the multidisciplinary trauma committee for analysis at regular intervals to meet the needs of the trauma program.	E	E	E	E	E
The results of issue analysis will define corrective action strategies or plans that are documented.	E	E	E	E	E
Use of telehealth for collaborative care of the trauma patient requires inclusion of the off-site service in the PI process.	E	E	E	E	E
The results or effectiveness of the corrective action plans/strategies are documented.	E	E	E	E	E
Programs that admit more than 10% of trauma patients to All nonsurgical services admissions should be subject to individual case review to determine rationale for admission onto a non-surgical service, adverse outcomes, and opportunities for improvement.	E	E	E	D	
Neurotrauma care should be routinely evaluated as to for compliance with the Brain Trauma Foundation Guidelines.	E	E	E	D	
All trauma deaths and transfers to hospice must be reviewed with analysis done to identify opportunities for improvement. Deaths must be categorized as either: • Mortality with opportunity for improvement; or • Mortality without opportunity for improvement.	E	E	E	E	E
Must have standardized treatment protocols for geriatric trauma management.	E	E	D	D	D
All transfers of trauma patients to a higher level of care both within the hospital and via interfacility transfer must be routinely monitored, and identified cases reviewed to determine rationale for transfer, adverse outcomes, and opportunities for improvement.	E	E	E	E	E
Must have protocols and processes in place that determine the rehabilitation needs and services required during the acute inpatient stay and to determine the level of care patients require after discharge.	E	E	E		

E = Essential Criteria (required) D = Desired Criteria (not required)   18

Montana Trauma Facility Resource Criteria

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The trauma program will participates in benchmarking with other facilities of the same designation level to identify how the trauma center performs compared to others.	E	E	E	E	E
PATIENT CARE EXPECTATIONS & PROTOCOLS					
Diversion Policy					
A written policy and procedure to divert patients to another designated trauma care service when the facility's resources are temporarily unavailable for optimal trauma patient care. Must include a process for notification of affected EMS services and outlying facilities.	E	E	E	E	E
All trauma patients who are diverted to another trauma center, acute care hospital, or specialty center must be subjected to performance improvement case review. Documentation showing reasons for, and duration of diversion is required.	E	E	E	E	E
Diversion cannot exceed 400 hours during the reporting period and all instances must be reviewed by the trauma committee.	E	E	E	E	E
Organ Procurement					
Must have an affiliation with an organ procurement organization.	E	E	E	E	E
Must have a written policy for notification of the regional organ procurement organization.	E	E	E	E	E
Must have protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.	E	E	E	D	D
Inter-Facility Transfer					
Inter-facility transfer guidelines and agreements consistent with the scope of the trauma service practice available at the facility.	E	E	E	E	E
Must have clearly defined transfer protocols that include the types of patients and expected time frame for initiating transfer to predetermined referral centers for outgoing transfers.	E	E	E	E	E
Decision to transfer a patient must be based solely on the needs of the injured patient without consideration of their health plan, payor status, or affiliation with a healthcare system.	E	E	E	E	E
The transferring provider must directly communicate with the receiving provider to ensure safe transition of care when transferring a patient. This communication may occur through a transfer center.	E	E	E	E	E
Feedback regarding trauma patient transfers shall be provided to the trauma program at the transferring hospital in a timely manner after patient discharge from the receiving hospital.	E	E	E		
The trauma coordinator at the transferring hospital is encouraged to contact the Regional Trauma Center/Area Trauma Hospital receiving facility trauma coordinators for verbal feedback.	E	E	E	E	E
All trauma patients who are transferred during the acute hospitalization to another trauma center, acute care hospital or	E	E	E	E	E

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Montana Trauma Facility Resource Criteria

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specialty center must be subjected to performance improvement case review.					
Signed and current ~~within last 6 years,~~ inter-facility transfers agreements for transfer of special population trauma patients to a higher level of care.	E	E	E	E	E
Burn Care – Organized					
In-house or transfer agreement with Burn Center	E	E	E	E	E
Acute Spinal Cord Management					
In-house or transfer agreement with Comprehensive/Regional Trauma Center	E	E	E	E	E
Pediatrics					
In-house or transfer agreement with Comprehensive/Regional or Area Trauma Center ~~or~~ with pediatric trauma care capability or a Pediatric Hospital.	E	E	E	E	E
CONTINUING EDUCATION / ~~OUTREACH/~~ RESEARCH					
Clinical trauma education provided by hospital for:					
Physicians, physician assistants & nurse practitioners	E[2]	E[2]	E[2]	E[2]	E[2]
Nurses	E[2]	E[2]	E[2]	E[2]	E[2]
Allied health personnel	E[2]	E[2]	E[2]	E[2]	E[2]
Prehospital personnel	E[2]	E[2]	E[2]	E[2]	E[2]
Must provide trauma orientation to new nursing and provider staff caring for trauma patients.	E	E	E	E	E
The trauma center will participate in a TEAM course every 3 years or when significant change in staff warrants additional training.				D	D
Research					
All residents on the trauma service must be from an Accreditation Council for Graduate Medicine Education (ACGME) accredited program.	E				
Demonstrate commitment to postgraduate training by having residency rotations in trauma with a defined trauma curriculum. Rotations in general surgery, orthopedic, neurosurgery and emergency medicine with sufficient volume to meet competency requirements set forth by ACGME.	E				
Research portfolio should be balanced to reflect the diverse aspects of trauma care and include peer-reviewed articles published in journals that results from work related to the trauma center or the trauma system in which the center participates.	E				

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Montana Trauma Facility Resource Criteria

INJURY PREVENTION & DISASTER PRPAREDNESS					
Must provide public trauma/injury prevention education.	E	E	E	E	E
The trauma center implements at least two activities over the course of the 3-year designation period with specific objectives and deliverables that address separate major causes of injury in the community.	E	E	E	E	E
The trauma center has a designated injury prevention coordinator or spokesperson (can be the trauma coordinator/trauma program manager for ATH, CTH & TRF), with adequate hours to perform duties.	E	E	E	E	D̶ E
Identified injury prevention professional must be someone other than the trauma program manager or PI personnel.	E	E	D		
Injury prevention priorities are based on local/state data.	E	E	D̶ E	D̶ E	D̶ E
Collaboration with existing national, regional and state programs Demonstrates evidence of partnerships with community organizations to support injury prevention efforts.	E	E	D̶E	D̶ E	D̶E
Monitor progress / effect of prevention program	E	E	D̶ E	D	D
There is a mechanism to identify trauma patients with alcohol and drug misuse issues Must screen at least 80% of all admitted patients over age 12 for alcohol misuse with a validated tool or routine blood alcohol content testing.	E	E	E	D	D
The trauma center has the capability to provide intervention or referral for trauma patients identified with alcohol and drug misuse issues. At least 80% of patients who have screened positive for alcohol misuse must receive a brief intervention by trained staff and must be documented.	E	E			
At least 80% of patients who have screened positive for alcohol misuse must have a mechanism for referral if brief intervention is not available as an inpatient.			E		
There is a protocol to screen patients at high risk for psychological sequelae with referral to mental health provider.	E	E	D		
A process for referral to a mental health provider when required.			E	D	D
Disaster Preparedness					
There is a written emergency operation plan that is updated and exercised routinely.	E	E	E	E	E
Ability to decontaminate single and multiple injured patients prior to entry to the facility.	E	E	E	E	E
Participation in regional disaster/emergency management activities including Local Emergency Planning Committee (LEPC), health care coalitions, and regional mass casualty exercises.	E	E	E	E	E
Active hospital representation on the Local Emergency Planning Committee (LEPC)	E	E	E	E	E
The trauma surgeon liaison to the disaster committee must complete the Disaster Management and Emergency Preparedness Course at least once.	E	D	D		
A trauma surgeon from the trauma panel must be included as a member of the hospital's disaster committee and be responsible for the development of a surgical response to a mass casualty event.	E	E	E		
An orthopedic surgeon from the orthopedic trauma call panel serves as a member of the hospital's disaster committee.	E				
The trauma program must participate in two hospital drills or disaster plan activations per year that include a trauma response and are designed to refine the hospital's response to mass casualty events. A	E	E	E	E	E

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Proposed – See MAR Notice 37-1026. New matter underlined; deleted matter interlined.

Montana Trauma Facility Resource Criteria

facility that is involved in one or more real-world disaster events having a trauma component and requiring activation of the disaster plan is exempt from participating in drills. ~~Routine participation in disaster drills. At least 2 drills per year. One must be live, one with an influx of patients and one that involves the community plan~~					

~~1   Alternate criteria for board certification are the physician must have completed an approved residency program, be licensed to practice medicine, be approved by the hospital credentialing committee, and have experience caring for trauma patients which must be followed in the performance improvement program.~~

1   Alternate Pathway requirements include:
   a.   Completion of training equivalent to that required by the United States or Canada.
   b.   Evidence of 36 hours (12 hours annually prorated for new hires) of trauma-related CME during the verification cycle. For pediatric trauma care, 9 of 36 hours must be pediatric-specific CME.
   c.   Hold current ATLS certification.
   d.   Hold active membership in at least one national or regional trauma organization and attended at least one meeting during the reporting period.
   e.   Trauma multidisciplinary PIPS committee meeting attendance rate of 50 percent or more during the reporting period.
   f.   Credentialed to provide trauma care.
   g.   Processes and outcomes of care must be comparable to that of other physicians.

~~1~~2   Trauma continuing education can be obtained in a variety of ways such as attending facility trauma committee and peer review meetings (attendance may be met through teleconferencing or videoconferencing participation.) which provide education, Regional Trauma Advisory Committee (RTAC) meetings and State Trauma Care Committee (STCC) meetings. External trauma-related education can be obtained outside of one's own institution and/or by educators from outside the institution.

E*   Applies only to Area Trauma Hospitals (Level III-N) with neurotrauma capabilities.

***
Brief description of trauma designation levels:
   • Comprehensive Trauma Centers (CTC): Definitive comprehensive care for complex multisystem injured patients. Research conducted at facility. Residency program affiliation. Leader in professional and community education and system planning.
   • Regional Trauma Centers (RTC): Initiate and provide definitive care for all injured patients. Assists with leadership for a geographical area or in lieu of CTC, which includes outreach to small facilities within the same service area.
   • Area Trauma Hospitals (ATH): Provide prompt assessment, resuscitation, surgery, intensive care, and stabilization for most injured patients.
   • Community Trauma Facilities (CTF): Provide evaluation, stabilization, diagnostic capabilities, and some surgical coverage for injured patients.
   • Trauma Receiving Facilities (TRF): Provide initial evaluation, stabilization, and diagnostic capabilities prior to transfer to definitive care. No surgical capabilities at facility.